STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	**HIGHWAY 11 BOONEVILLE, KY 41314**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY21193) was initiated on 01/14/14 and concluded on 01/15/14. The complaint was substantiated with Immediate Jeopardy identified at "J" level. Immediate Jeopardy and Substandard Quality of Care were identified at 42 CFR 483.25 Quality of Care (F323) on 01/15/14 and was determined to exist on 01/08/14. On 01/08/14, the facility failed to ensure residents' environment remained free of accident hazards. The facility's failure provided Resident #1 access to an unsecured medication cart. Review of the facility's video surveillance footage and interviews conducted on 01/14/14 revealed on 01/08/14, Resident #1 opened a medication cart located in the hallway that had been left unlocked and unattended by the medication nurse. Resident #1 retrieved a "blister pack" of medication and placed the medication under his/her shirt. Resident #1 proceeded out of view of the video and in the direction of a lounge area of the facility. Continued interview and review of a witness statement revealed Resident #1 was observed to be in the lounge area and had "a card of pills." According to the witness report, he/she heard a "popping sound" and the resident was observed to have "placed a pill" in his/her mouth. The resident was assessed after the incident with no negative effects identified. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 01/15/14 which alleged the Immediate Jeopardy was removed on 01/10/14. The State Survey Agency verified the Immediate Jeopardy was removed on 01/10/14 which was prior to the initiation of the investigation; therefore, it was determined to be Past Jeopardy.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical records, facility policies, the facility's incident reports and investigation, and video surveillance, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible for one (1) of three (3) sampled residents (Resident #1). The facility failed to ensure facility staff provided care in accordance with the facility's policy entitled "Preparation and General Guidelines for Administering Medications," dated 12/18/12, that required medication carts to be closed and locked when out of sight of the Medication Nurse or Certified Medication Aide. The facility's failure provided Resident #1 access to an unlocked and unsecured medication cart. Review of the facility's video surveillance footage revealed on 01/08/14, Resident #1 opened a medication cart located in the hallway that had been left unlocked and unattended by the medication nurse. Resident #1 retrieved a "blister pack" of medication and proceeded, out of view of the video, in his/her wheelchair into the direction of a lounge area of the facility. Continued interview and review of a witness statement revealed Resident #1 was observed to be in the lounge	F 323	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2	F 323		

area with a "card of pills." The witness reported he/she heard a "popping sound" and the resident was observed to have "placed a pill" in his/her mouth. The resident was assessed after the incident with no negative effects identified.

The facility's failure to ensure the resident environment was as free from accident hazards as is possible has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy and Substandard Quality of Care were identified at 42 CFR 483.25 Quality of Care on 01/15/14 and was determined to exist on 01/08/14. The facility provided an acceptable Credible Allegation of Compliance (AOC) on 01/15/14 which alleged the Immediate Jeopardy was removed on 01/10/14. The State Survey Agency verified the Immediate Jeopardy was removed on 01/10/14 which was prior to the initiation of the investigation; therefore, it was determined to be Past Jeopardy.

The findings include:

Review of the facility's policy titled "Preparation and General Guidelines for Administering Medication," dated 12/18/12, revealed during medication administration staff was required to keep the medication carts closed and locked when out of sight of the medication nurse or aide.

Review of a facility incident report, dated 01/08/14, revealed at approximately 4:22 PM on 01/08/14, a facility visitor notified Licensed Practical Nurse (LPN) #1 that Resident #1 was observed in the East Lounge "taking pills." Continued review of the incident report revealed Resident #1 was observed in the East Lounge sitting in a wheelchair, and had a "medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3	F 323		

card" of Lortab (narcotic pain medication). Further review revealed the "blister pack" of medications had contained 30 pills and 2 of the pills were missing from the pack. The "blister pack" of medications was retrieved from the resident and LPN #1 notified the Unit Manager, the resident's Responsible Party, and the Physician of the incident. LPN #1 was immediately suspended from the facility, pending the outcome of the investigation.

Review of Resident #1's medical record revealed the facility admitted the resident on 09/25/09, with diagnoses that included Osteoarthritis, Anxiety, and a history of a Right Hip Fracture and Chronic Pain. Review of the Quarterly Minimum Data Set Assessment (MDS) dated 11/13/13, revealed the facility assessed Resident #1 to require extensive assistance with transferring and bathing. The assessment also revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 and was interviewable.

Review of the Comprehensive Care Plan for Resident #1 revealed facility staff had revised the resident's care plan on 11/20/13 and had assessed the resident to have the potential for altered comfort and behaviors. The facility also assessed the resident to have a history of demanding pain medications before they were scheduled to be administered. There was no documentation on the care plan that Resident #1 had attempted to gain access to medications without staff knowledge prior to the incident on 01/08/14.

Interview conducted with Resident #1 on 01/14/14 at 11:10 AM revealed he/she had taken a pack of medications that was "sitting on top of the cart,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4	F 323		

when the nurse went down the hall." The resident stated, "They take good care of me here, I just wanted some more medicine and they looked like the ones I take."

Review of the facility's video footage revealed on 01/08/14 a nurse, identified by facility staff to be LPN #1, was observed to prepare medications at a medication cart located in the hallway. Resident #1 was observed positioned near the medication cart in a wheel chair. The medication cart was observed to be in a closed position and the LPN was observed to touch the outside of the cart, as if to lock the cart, and then walk away from the cart. Resident #1 was observed to wheel him/herself up to the medication cart, open the outside door of the medication cart, and proceed, without difficulty, to pull out and open a drawer identified by staff to be the drawer that held narcotics. The resident was observed to remove a "blister pack" of medication from inside the narcotics drawer and then he/she closed the narcotics drawer and the outside door of the cart. Further observation revealed Resident #1 touched the outside of the cart, placed the "blister pack" of medication under his/her shirt, and wheeled him/herself in the wheelchair out of view of the camera in the direction of a lounge area a short distance away. Review of the video revealed, after a short timeframe, LPN #1 returned to the medication cart and attempted to open the cart without the use of a key, but was unable to open the door to the medication cart. Further review of the video revealed the LPN retrieved a key from a front pocket of her uniform, and attempted to use the key to access the cart. However, observation of the video revealed a visitor approached and spoke to the LPN and both the LPN and the visitor walked quickly in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 5	F 323		

direction of the lounge area where Resident #1 had been observed to wheel himself/herself.

Review of Resident #1's medical record revealed LPN #1 notified the resident's physician of the incident on 01/08/14 at 4:44 PM and the physician requested for facility staff to "hold" the resident's doses of Norco 10-325 mg on 01/08/14 at 6:00 PM and on 01/09/14 at 12:00 AM; and to resume the medication on 01/09/14 at 6:00 AM. In addition, a review of Resident #1's care plan revealed facility staff developed a care plan intervention on 01/08/14 (no time noted) to "monitor" the resident "one on one" until "7:00 AM" for symptoms of "pain," "respirations," and the resident's "level of consciousness." Based on documentation, facility staff monitored Resident #1 and documented their observations of the resident every 15 minutes from 5:00 PM on 01/08/14 through 7:00 AM on 01/09/14 without any concerns identified.

Interview with LPN #1 on 01/14/14 at 1:40 PM, confirmed she was responsible for the medication cart when the resident obtained medications from the cart on 01/08/14. The LPN stated during a medication pass on 01/08/14, she had locked the outside lock of the medication cart and the narcotics drawer located inside the medication cart before she left the cart to administer medications. LPN #1 acknowledged that she had been informed by a visitor that when she left the medication cart to administer medications, Resident #1 had taken a card of medications from the cart and had swallowed some of the medications. LPN stated she obtained the card of medications from the resident and asked a nearby staff member to inform the Unit Manager of the incident. LPN #1 stated Resident #1 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

never attempted to gain access to the facility's medication carts prior to this incident.

Interview with the Unit Manager, Registered Nurse (RN) #2, on 01/14/14 at 2:57 PM revealed she was in the facility at the time of the incident with Resident #1 on 01/08/14 and was immediately notified when the incident occurred. RN #2 stated she immediately assessed and conducted an audit of all medication carts in the facility to ensure the carts could be properly secured and did not identify any concerns. The RN further stated she and other licensed staff members counted all of the narcotics in the facility to ensure accountability of the medications after the incident occurred on 01/08/14. The RN stated the only discrepancy identified was the medications Resident #1 had retrieved from the medication cart. The Unit Manager stated to her knowledge, Resident #1 had never attempted to gain access to medication carts before the incident on 01/08/14.

Interview with the Director of Nursing (DON) on 01/14/14 at 4:03 PM revealed she was immediately notified of the incident on 01/08/14 and notified the Administrator and the Social Services Director. The DON stated she interviewed LPN #1 related to the incident and suspended the LPN pending the investigation.

Interview on 01/14/14 with the facility's consultant Pharmacist revealed the DON of the facility had informed her of the incident on 01/08/14, was "very upset," and wanted all the medication carts and locks on the carts to be assessed. The Pharmacist stated all medication carts in the facility were immediately assessed and no concerns were identified related to the security of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 7	F 323		

the carts.

Continued interview with the DON revealed on 01/14/14 at 4:03 PM the facility conducted an investigation of the incident and in-serviced staff on how to properly secure the medication carts. The DON stated she and other Nurse Management staff continued to conduct audits of medication carts, at least once a shift, to ensure they were secure, and no concerns had been identified.

Interview with the Administrator on 01/14/14 at 4:20 PM revealed as a result of the facility's investigation, it had been determined LPN #1 had not followed facility policy and had failed to ensure the medication cart was secured before leaving it unattended on 01/08/14. The Administrator stated facility administrative nursing staff, including the DON, immediately audited all medication carts to ensure medications were accounted for and also contacted the facility's pharmacist to inform him of the incident. The Administrator continued to state audits of medication carts and staff in-service with return demonstration on the security of the medication carts were implemented immediately and continued to be conducted by administrative nursing staff, a minimum of once per shift, to ensure all medication carts were secure. In addition, the Administrator stated a pharmacy employee also audited the medication carts on 01/08/14 and no concerns were identified. The Administrator stated she reviewed the audit results daily, and no concerns had been identified.

*Review of the Allegation of Compliance (AOC) revealed the facility implemented the following

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8	F 323		

corrective actions:

The facility alleged the Allegation of Compliance was implemented on 01/08/14 at approximately 4:30 PM, and that interventions were ongoing.

On 01/08/14, the resident involved was immediately evaluated by a Registered Nurse (RN) and placed on increased monitoring (one on one), and the resident's physician and Power of Attorney were notified. No negative outcome was observed.

The licensed nurse (LPN #1) involved was suspended on 01/08/14 and is no longer employed at the facility.

The medication cart was secured (locked) in the medication room immediately. A thorough review of the medication cart was conducted by the Director of Nursing (DON) on 01/08/14. All medication and treatment carts were evaluated and were found to be functioning properly. Narcotic counts were completed by the DON, the Unit Manager, and two licensed nurses. There were no other discrepancies noted with the counts.

The facility pharmacy was contacted by the DON on 01/08/14. On 01/08/14, a pharmacy employee reviewed the medication carts in the facility and found them to be in proper working order. Per the request of the facility's Director of Nursing, the narcotics lock was replaced on the medication cart used by the nurse involved.

Beginning on 01/08/14, in-services were conducted for Licensed Nurses and Certified Medication Aides regarding properly securing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9	F 323		

medication carts. Licensed Nurses and Certified Medication Aides were not permitted to work until education was confirmed by return demonstration checks.

Beginning 01/08/14, audits were initiated to review the security of the medication carts. A minimum of once per shift audits continued through 01/09/14 and are ongoing. There have been no negative findings. Audits will be completed by the facility's nurse management staff, including the DON, RN Unit Managers, RN MDS Coordinators, and the RN Medical Records Director. The facility Administrator reviews the results of the audits daily.

To ensure sustained compliance, the facility's pharmacy will continue with medication pass skills reviews on Licensed Nurses and Certified Medication Aides. Additional in-servicing and skill checks will be completed by the pharmacy beginning on 01/16/14. The nurse management staff will continue to complete audits at least once each shift to ensure security of the medication carts every shift. Any concerns identified will be investigated and addressed immediately in accordance with the facility's policies and the employee handbook. Concerns will also be submitted to the Quality Assurance (QA) Committee for review and further interventions.

Monthly in-services will be provided to all Licensed Nurses and Certified Medication Aides on medication pass, medication storage, and security of medication carts. In-servicing will be provided by the facility's nurse management staff and/or the pharmacy.

Members of the QA Committee reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

investigation results and approved interventions outlined above on 01/09/14. The facility Medical Director was also consulted on 01/09/14. A follow-up QA Committee meeting was scheduled for 01/16/14. Results of the audits will continue to be submitted to the QA Committee for review. Monitoring will occur through weekly QA Committee meetings. This committee will review the audits and any investigations and implement changes as needed.

The facility maintains the concern identified on 01/08/14 was investigated and corrected on 01/10/14.

**The SSA validated the facility's corrective action as follows:

Interviews and review of the facility's documentation revealed Resident #1 was assessed by licensed nursing staff, and placed on one on one supervision until 7:00 AM on 01/09/14 and was assessed not to have experienced any negative effects as a result of the incident. The facility notified the resident's physician and responsible party of the incident.

Interviews with the Director of Nursing (DON) on 01/14/14 at 4:03 PM, and the Administrator on 01/14/14 at 4:20 PM, and review of the facility's documentation confirmed medication carts, facilitywide, were secured and the Unit Manager, the DON, and facility staff conducted a facilitywide audit of medications to ensure accuracy and accountability. Continued review and interview revealed facilitywide narcotic counts were conducted and no concerns were identified.

Interviews with the Administrator on 01/14/14 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11	F 323		

4:20 PM confirmed the DON had informed pharmacy staff of the incident and the pharmacy staff had also conducted an audit of all medication carts in the facility for proper functioning.

Interviews with the Director of Nursing (DON) on 01/14/14 at 4:03 PM, and the Administrator on 01/14/14 at 4:20 PM, and a review of the facility's documentation confirmed the facility conducted an investigation of the incident and, as a result, LPN #1's employment at the facility had been terminated.

Interviews with RN #1, LPN #1, LPN #2, and CMA #1 conducted on 01/14/14 and record review confirmed when the incident occurred on 01/08/14, staff was in-serviced and was required to perform a return demonstration to ensure competency in securing the medication carts. Interviews with the DON and the Administrator on 01/14/14 also confirmed staff was not permitted to work until in-services and competency checks had been conducted.

Interviews and review of the facility's audits confirmed audits were initiated on 01/08/14 and had been conducted by the facility's nurse management staff, at least once per shift since 01/08/14 and were ongoing. An interview with the Administrator confirmed she reviewed the audits daily for accuracy and no concerns had been identified. The Administrator stated the audits would be conducted on an ongoing basis, concerns would be corrected immediately, and the audit findings would be reviewed through the weekly QA Committee.

Continued review of the facility's AOC and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185273	A. BUILDING _____ B. WING _____	C 01/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWSLEY COUNTY HEALTH CARE CENTER, INC	HIGHWAY 11 BOONEVILLE, KY 41314

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 interview with the Administrator confirmed the facility would continue to in-service RNs, LPNs, and CMAs on a monthly basis related to the security of medications to ensure sustained compliance. In addition, Nurse Management staff will continue to conduct audits at least once each shift to ensure medication carts are secure. Any concerns identified will be submitted to the QA Committee for review and to implement further interventions if required. Continued review of the facility's AOC and interview with the Administrator confirmed a follow-up QA meeting was scheduled for 01/16/14, and facility staff would continue to monitor the facility's compliance through the weekly QA meetings.	F 323		